TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Shannon Medical Center

**Respondent Name**
Old Republic Insurance Co

**MFDR Tracking Number**
M4-16-0222-01

**Carrier's Austin Representative**
Box Number 44

**MFDR Date Received**
September 25, 2015

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "HRA has been hired by Shannon Medical Center to audit their Workers Compensation claims. We have found in this audit they have not paid what we determine is the correct allowable per the new fee schedule that took effect in March of 2008 for this outpatient surgery."

**Amount in Dispute:** $5,532.85

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on October 5, 2015. The insurance carrier did not submit a response for consideration in this review. Per 28 Texas Administrative Code §133.307(d)(1), "If the Division does not receive the response information within 14 calendar days of the dispute notification, then the Division may base its decision on the available information." Accordingly, this decision is based on the available information.

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| October 6, 2014 | Outpatient Hospital Services | $5,532.85 | $5,532.85 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 954 – The allowance for normally packaged revenue and/or service codes have been paid in accordance with the dispersed outpatient allowance
   - 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed
   - 847 – In accordance with OPPS guidelines, the billed revenue codes require HCPCS/CPT coding.

**Issues**

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

**Findings**

1. This dispute relates to outpatient hospital facility services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was requested. However, 28 Texas Administrative Code §134.403 (g)(1)states,

   > A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

   Review of the submitted documentation finds insufficient evidence to support this requirement was met. Therefore the services in dispute will be reviewed per Rule 134.403(f)(1).

2. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

   - Procedure code 62362 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0227, which, per OPPS Addendum A, has a payment rate of $14,649.77. This amount multiplied by 60% yields an unadjusted labor-related amount of $8,789.86. This amount multiplied by the annual wage index for this facility of 0.866 yields an adjusted labor-related amount of $7,612.02. The non-labor related portion is 40% of the APC rate or $5,859.91. The sum of the labor and non-labor related amounts is $13,471.93. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $2,900, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.178. This ratio multiplied by the billed charge of $1,399.00

yields a cost of $249.02. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $13,471.93 divided by the sum of all APC payments is 100.00%. The sum of all packaged costs is $8,246.30. The allocated portion of packaged costs is $8,246.30. This amount added to the service cost yields a total cost of $8,495.32. The cost of these services exceeds the annual fixed-dollar threshold of $2,900. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total Medicare facility specific reimbursement amount for this line is $13,471.93. This amount multiplied by 200% yields a MAR of $26,943.86.

3. The total allowable reimbursement for the services in dispute is $26,943.86. The amount previously paid by the insurance carrier is $11,170.50. The requestor is seeking additional reimbursement in the amount of $5,532.85. This amount is recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $5,532.85.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $5,532.85 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

**Authorized Signature**

| | | |
|---|---|---|
| | | November , 2015 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.